DAY SERVICES TREATMENT PLAN

Day Services Treatment Plan Development Date: _____

SECTION 1: Identifying Information

A. Consumer's Full Name: _____

B. Date of Birth: _____

C. Social Security #: _____

D. Medicaid #: _____

E. Home Telephone Number & Address: _____

F. Primary Contact: _____

G. Emergency Contact: _____

H. Authorized Service:

Day Habilitation	☐	
Prevocational	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

I. Funding source:

MR/RD Waiver	☐	
Medicaid State Plan	☐	
Rehabilitation Supports	☐	
Other	☐	Specify: _____

J. Primary Service Location:

Center Based	☐	
Enclave	☐	
Mobile Work Crew	☐	
Other	☐	Specify: _____

K. Service Coordination Level: *(Check appropriate box)*

Level I _____

Level II _____

SECTION 2: Critical & Emergency Information

A. Critical Information: _____

B. Emergency Disaster Preparedness Plan Information: _____

C. Additional emergency Information _____

SECTION 3: Health Information

A. Primary Care Physician _____

B. Hospital of choice _____

C. List any known allergies _____

D. List **all** medicine(s) taken by this consumer

_____ **or** ☐ See attached list of all medications taken by this consumer

- Specific instructions concerning **reactions to (Example: side effects to watch for) or restrictions** for (Example: Types of foods to avoid, exposure to sun, etc.) all medication taken by consumer. _____

E. Medication Administration:

- List **all** medicine(s) to be taken by this consumer **while at the Day Program**

_____ **or** ☐ **See attached list of all medications taken by this consumer while at the Day Program**

☐ Consumer (self medicating)

☐ Consumer with assistance from Direct Support Staff

- Specific instructions concerning medication administration: _____
- Specific instructions concerning **reactions to (Example: side effects to watch for) or restrictions** for (Example: Types of foods to avoid, exposure to sun, etc.) medication to be taken while in attendance at the Day Program. _____

F. Behavior Support Plan: Yes: ☐ **Review the BSP located in the consumer's file** No: ☐

G. Adaptive Equipment:

1. Assistive Technology Device(s) or Supplies required while in attendance at the Day Program _____

2. Schedule for use while in attendance at the Day Program _____

SECTION 4: Care and Supervision

A. Accountability Level (I-VIII): _____

B. Describe the care and supervision for this consumer:

- ***Document specific instructions on how and when this consumer is supervised,***
- ***Document special instructions concerning self-help care:***
  - ***Toileting***

    _____
  - ***Dining (special diets, restrictions, special preparation etc).***

    _____
  - **Other** _____

SECTION 5: Day Service Goals and Objectives

A. Assessment tool used: _____

B. Date Assessment completed: _____

C. Assessment results summary: _____

D. Goals:
Please Mark (x) the areas, identified through the assessment, on which the consumer will be working to increase and/or retain skills. List objectives that will assist the consumer in attaining each goal.

Day Habilitation Goals:

- Self Help ☐
- Socialization ☐
- Adaptive ☐
- Other **Specify**: _____

Objective: _____

Objective: _____

Prevocational Goals:

- Compliance ☐
- Endurance ☐
- Attendance ☐
- Task Completion ☐
- Problem Solving ☐
- Safety ☐
- Other **Specify:** _____

Objective: _____

Objective: _____

Rehabilitation Supports Goals:

- Personal Care ☐
- Cognitive/Independent Living ☐
- Medication Management ☐
- Health & Nutrition ☐
- Self-Esteem ☐
- Coping Skills ☐
- Personal Responsibility ☐
- Social Skills ☐
- Community Living ☐
- **Other** **Specify:** _____

Objective: _____

Objective: _____

E. Summary of progress and/or regression and interventions needed: See ***Day Program Monthly Progress Summary Note***

SECTION 6 Six Month Review Summary

A ONLY REQUIRED FOR REHABILITATION SUPPORT SERVICES

- Are current goals and objectives appropriate and effective in meeting the need and goals of the consumer?

  Yes ☐ No ☐

- Are there any other issues pertinent to the functioning of the consumer?

  ☐ Yes, explain: _____

  ☐ No

- Do the needs of the consumer support the continuation of rehabilitation support services?

  Yes ☐

  No: ☐, explain: _____

B. Signature: _____ _____
Lead Clinical Staff Date Reviewed

SECTION 7 Signatures

A. Signatures of persons approving Annual Treatment Plan

I have been provided with and understand the information of the services within this Day Services/Facility Based Rehabilitation Support Treatment Plan. I have participated in the development of this plan and agree to the conditions contained within.

B. Signatures:

_____ _____
Consumer Date

_____ _____
Parent or Guardian (*when necessary*) Date

_____ _____
Staff/LCS Date

DAY SERVICES TREATMENT PLAN
INSTRUCTIONS

SECTION 1: IDENTIFYING INFORMATION

This section is to identify all pertinent and current background information on the consumer that will assist the day program staff in providing services.

A. **Consumer's name**: Print consumer's legal full name (first and last). Use alternate name in parenthesis if it is the consumer's preference.

B. **Date of Birth**: Month/Day/Year

C. **Social Security Number:**

D. **Medicaid #**: When necessary

E. **Home address and telephone number**. Document street address where the consumer currently resides. Telephone where consumer resides as well as a contact number when applicable.

F. **Primary Contact**: Name, address and telephone of the primary contact for this consumer. This contact information may be the consumer's information, parent/guardian, or residential placement. This information is used to contact the consumer or those that he resides with.

G. **Emergency Contact:** Name address and telephone of the person to be called or notified **in an emergency**. This information may or may not be the same as the primary contact.

H. **Authorized Service:** Check the box next to the consumer's authorized service(s) as it is stated on the STS.

I. **Funding source**: Check the box next to the funding source that applies to this consumer.

1. For **Waiver funded Day Habilitation and Prevocational services** a ***MR/RD Waiver Authorization*** form is required.
2. For Prevocational Services a **MR/RD Waiver *Request for Determination of Availability of Service*** from **SC Vocational Rehabilitation is required.**
3. For **Facility Based Rehabilitation Supports**, the consumer must be a **Medicaid recipient**, **not be enrolled in the MR/RD Waive**r, **not reside in an Intermediate Care Facility for the Mentally Retarded or Nursing Home**, and have a **Medical Necessity Statement** approved and signed by a "licensed practitioner of the healing arts" prior to receiving services.

J. **Primary Service Location:** Check the box that indicates the primary location that the consumer will receive services.

K. **Service Coordination Level:** Check the appropriate box to indicate if the consumer is Level I or Level II Service Coordination. The Day Treatment Plan will be the consumer's only plan if they are Level II.

SECTION 2: CRITICAL AND EMERGENCY INFORMATION: In this section, document any and all critical information that is pertinent to this consumer. Be as specific and detailed as possible. This section must state what specific needs this consumer has and will need to be implemented in an emergency situation.

SECTION 3: HEALTH INFORMATION

This section provides a health history for the consumer. For the safety and well being of the consumer it is important that all pertinent health information for this individual be documented in this section.

A. **Primary Care Physician:** Document the name of the consumer's primary care physician with address and phone numbers.

B. **Hospital of choice:** Indicate the consumer's or designated caregiver's choice as to which hospital the consumer wishes to be taken in case of an emergency.

C. **Allergies**: List all known allergies with instructions on allergic reactions and medication.

D. **Medicines:** List **all** medicines the consumer is taking or check the box indicating a comprehensive list of all medications with dosage is attached. Indicate name of medicine, purpose for taking the medicine, and the dosage and frequency taken. List **all** medicine the consumer is taking, even if he is not taking that medicine while in the day program. Be aware of appropriate procedures in case of any possible reaction to any medicine or if over/under medicated. **It is imperative that accurate records are charted when medication is administered.**
Specific Instructions: List any and all **specific** instructions as to what type of reaction from the medication is possible, instructions on how to tell if the consumer is being under medicated as well as over medicated, types of food to avoid while taking this medication, limitations (Example: exposure to the sun, etc.) and all possible side effects to be aware of.

E. **Medication Administration**: List **all** medicines the consumer is taking while at the Day Program or check the box indicating a comprehensive list of all medications with dosage is attached. A generic list of reactions to the medicine is not sufficient; it must be specific to this consumer. Indicate name of medicine, purpose for taking the medicine, and the dosage and frequency taken. Indicate if the consumer self medicates or needs assistance. It is important to indicate any specific instructions regarding the consumers' medication administration.

Specific Instructions: List any and all specific instructions as to what type of reaction from the medication is possible, instructions on how to tell if the consumer is being under medicated as well as over medicated, types of food to avoid while taking this medication, limitations (Example: exposure to the sun, etc.) and all possible side effects to be aware of.

F. **Behavior Support Plan (BSP):** Indicate yes or no if the consumer has a BSP. If yes, review the plan located in the consumer's file.

G. **Adaptive Equipment**: Indicate any and all assistive technology device(s) or supplies required by the consumer used during the course of the day while in attendance at the Day Program and indicate the schedule for use.

SECTION 4: CARE AND SUPERVISION:

A. **Accountability Level:** Indicate the Accountability Level (I – VIII) for this person.

B. **Describe the care and supervision for this consumer:**

SUPERVISION:

In **specific detail** explain how this consumer is supervised and at what times and the frequency of supervision. Special consideration will be given to insure the consumer is not **under** supervised or **over** supervised according to his level of needed supports.

CARE:

Document in specific detail any special instructions concerning care (Example: walking and sitting endurance, specific type of seating apparatus and or accessories, repositioning frequency for chair bound individuals, any type of needed self care assistance, etc.) toileting, and/or dining (special diets, restrictions, special preparations, etc). **Be very clear with these special instructions and include all that are appropriate.**

SECTION 5: DAY SERVICE GOALS AND OBJECTIVES:

A. **Assessment tool used:** Document the name of the assessment tool used to determine the goals and objectives for this consumer. The goals and objectives listed on the Day Plan must reflect the results derived from the assessment given.

B. **Assessment Date**: Indicate the date assessment was administered. Assessments are to be administered annually.

C. **Assessment results summary:** Briefly summarize the results derived from the assessment and indicate the needed goals.

D. **Goals:** Mark the area(s) of the day services on which the consumer will be working on goals to increase and/or retain skills. The goals and objectives must be in accordance with the authorized service as stated on the STS. Additional goals outside of the authorized service may be addressed only if the major focus of the goals on the plan addresses the authorized services. For example a consumer may be authorized to receive Prevocational services but may require an additional day habilitation objectives to aid or assist in the success of the authorized service. These goals may be documented under "other".

Objectives: List all objectives that will be worked on by this consumer to enable him to attain the desired goals. The listed objectives must be in related to the checked goals of the service and in accordance with the needs outlined within the consumer's Single Plan.

E. **Summary of Progress**: For information on the progress of the goals and objectives for this consumer see the ***Day Program Monthly Progress Summary Note*** for specifics. The ***Day Program Monthly Progress Summary Note*** is maintained in the consumer's file.

SECTION 6: SIX MONTH REVIEW SUMMARY: ***(REQUIRED ONLY FOR REHABIITATION SUPPORT SERVICES)***

A. Six (6) months after the annual treatment plan has been implemented, the Lead Clinical Staff or Life skills specialist must evaluate the consumer's treatment plan to assess:

1. Are current goals and objectives appropriate and effective in meeting the needs and goals of the consumer?
2. Are there any other issues pertinent to the functioning of the consumer?
3. Do the needs of the consumer support the continuation of rehabilitation support services?

B. **Signatures**: The signature of the Lead Clinical Staff is required on all six (6) month reviews. The date of the review is required and must be within the six month time frame from implementation date on the plan.

SECTION 7: SIGNATURES:

A. A **signature** of persons (staff/LCS) approving the Annual Treatment Plan and **date** plan was signed is required on **all** Day Treatment Plans.

B. The **signature** of the **consumer** and **date** signed is required on **all** Day Treatment Plans, to indicate they have participated in the development of the plan and they understand and agree to the conditions contained within the plan. Parent or guardian signatures are required only when necessary (i.e. the consumer has been adjudicated as incompetent).